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ABSTRACT

The relationship of parent personality to child psychopathology has been investigated in numerous studies over the past three decades, using the Minnesota Multiphasic Personality Inventory (MMPI). To investigate response patterns of both parents and offspring, the MMPI responses of 197 families with adolescents entering inpatient or outpatient settings (N=555) were examined. Principal diagnoses for the outpatient sample were personality, academic and cognitive, and conduct and adjustment disorders and for the inpatient sample were dysthymic, personality, and conduct disorders. The results indicated that inpatient parents and adolescents had significantly higher mean scores across a variety of MMPI scales than did their outpatient counterparts. The linear combination of adolescent and maternal MMPI scale data, in a stepwise discriminative function analysis, resulted in accurate classification of 75 percent of all children in inpatient treatment and 74 percent of all children assigned to outpatient treatment. Results of the chi-square analyses indicated that the occurrence of clinical range maternal profiles was significantly related to an increased frequency of marked clinical profiles for both male and female offspring. The findings support the importance of treatment efforts which are responsive to the psychological features of the parents as well as the symptomatology of the adolescent. (LLL)

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# Parent and Child MMPI Responses: Characteristics Among Families with Adolescents in Inpatient and Outpatient Setting

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Running Head: PARENT AND CHILD MMPI

Abstract

The relationship of parent personality to child psychopathology has been investigated in numerous MMPI studies over the past three decades. Very few of these studies, however, have directly analyzed MMPI response patterns of both parents and offspring. The current study included the MMPI responses of 197 families with adolescents entering inpatient and outpatient psychiatric settings (N=555). Inpatient parents and adolescents had significantly higher mean scores across a variety of MMPI scales than did their outpatient counterparts. The linear combination of adolescent and maternal MMPI scale data, in a stepwise discriminative function analysis, resulted in accurate classification of 75% of all children in inpatient treatment and 74% of all children assigned to outpatient treatment. Results of the chi-square analyses indicated that the occurrence of clinical range maternal profiles was significantly related to an increased frequency of marked clinical profiles for both male and female offspring. Findings were discussed in terms of salient MMPI differences between inpatient and outpatient families and shared psychopathological characteristics among family members with offspring in psychiatric treatment settings.

# Parent and Child MMPI Profiles: Characteristics Among Families With Adolescents in Inpatient and Outpatient Settings

Numerous theories of psychological development postulate a meaningful relationship between personality characteristics of parents and their offspring. This area has received substantial attention by MMPI researchers over the past three decades with literature reviews provided by Hafner, Butcher, Hall and Quast (1969) and Lachar and Sharp (1979). The latter authors have observed that these investigations have substantial importance to theoretical models of psychological development, as well as to applied treatment issues, such as the selection of intervention setting (inpatient or outpatient) and type or combination of therapies (e.g., individual or family).

In addressing this complex area of shared parent-child personality features, several approaches have been pursued. One important focus has been investigations of MMPI features demonstrated by parents of emotionally disturbed children, typically in contrast with groups of normal adults (Adrian, Vacchiano & Gilbart, 1966; Goodstein & Rowley, 1961; L'Abate, 1960; Lauterbach, London & Bryan, 1961; Liverant, 1959; Marks, 1961; Wolking, Quast & Lawton, 1966). These studies have consistently shown evidence of greater psychopathology among the MMPI profiles of parents of psychiatrically disturbed children. Other researchers have compared MMPI profiles of parents of psychiatrically disturbed children with those of parents of children with nonpsychiatric disabilities. Erickson (1969) and Miller and Keirn (1978) found equivalent levels of disturbance in MMPI profiles of parents of emotionally disturbed and mentally retarded children, a finding Erickson interpreted as supportive of her view that these parents manifested a

generalized stress reaction in response to dealing with disabled children. A majority of researchers, however, have reported greater MMPI elevations among parents of emotionally disturbed children than among parents of the retarded (Wolking et al., 1966), stutterers (Goodstein and Dahlstrom, 1956), children with cleft palate (Goodstein, 1960a, 1960b) or infants with gastrointestinal reactions (Pinneau and Hopper, 1958). Finally, studies comparing parents of psychiatrically disturbed children with samples of adults diagnosed or treated for psychiatric disturbance have reported significantly lower levels of pathological features for the parent group (e.g., Lauterbach et al., 1961; McAdoo and Connolly, 1975).

Taken together, this literature is consistent with the conclusion of Hafner et al. (1969) that "parents of children who are psychiatrically disturbed are themselves more disturbed than parents in general. However, there is some indication that they are not as disturbed as adult psychiatric patients" (p.185). While this view implicitly assumes a relationship between parent and child features, the nature of this relationship has not been clarified. A limited number of investigations have attempted to identify meaningful patterns by comparing parent and child MMPI responses in both normal samples (Butcher and Messick, 1966; Hill and Hill, 1973; Sopchak, 1958) and in samples of inpatient adolescents (Archer, Sutker, White and Orvin, 1978; Lauterbach, Vogel and Hart, 1962; Mlott, 1972; Smith, Burleigh, Sewel and Krisak, 1984). Findings have ranged from studies emphasizing the dissimilarity between parent and child features, particularly for more disturbed adolescents (Archer et al., 1978; Hill and Hill, 1973; Lauterbach et al., 1962) to investigations which have found significant patterns of

relationships for MMPI scales, especially correlations between same sex parents and adolescents (Sopchak, 1958; Smith et al., 1984). The interpretability of this literature, however, has been obscured by pervasive methodological problems. All of these studies have utilized relatively small samples of families and most, with the exception of Archer et al. (1978) and Butcher and Messick (1966), have employed simple univariate correlational analyses of individual MMPI scales as the exclusive evaluative approach. Among correlational studies, only Sopchak (1958) employed correction procedures for the use of single sample tests for multiple correlations. Additionally, all studies of psychiatrically disturbed adolescents have sampled only from inpatient settings. Finally, at least four of these studies (Archer et al., 1978; Butcher and Messick, 1966; Lauterbach et al., 1962; Mlott, 1972) statistically evaluated adolescent MMPI responses which had been converted to adult K-corrected T-scores. This procedure, as recently discussed by Archer (1984), results in substantial and marked distortions of adolescent profiles when viewed in comparison to the use of age-appropriate adolescent norms.

The present study examined what Hafner et al. (1969) termed the "interprofile" characteristics, or shared MMPI features between individuals, of 197 families with psychiatrically disturbed adolescents. Further, this study attempted to employ methodological improvements, in contrast to prior investigations, which would allow for more meaningful interpretation of findings. Thus, families were sampled from inpatient and outpatient settings, with the assessment of both parents and adolescents occurring prior to

major treatment effects. Further, emphasis was placed on the use of both univariate and multivariate statistical approaches which utilized the most appropriate units of measurements for data analyses.

## Methods

### Subjects and Settings

The study included 197 families (total N=555) with 12 to 18 year old adolescents entering treatment in three psychiatric settings. Seventy-nine families were from a private outpatient psychiatric clinic in Richmond, Virginia. This sample consisted of 25 female (mean age = 14.95 years) and 54 male adolescents (mean age = 15.48 years), 74 mothers (mean age = 41.05 years) and 65 fathers (mean age = 40.93 years). One mother and eight fathers in this sample were nonbiological parents, (i.e. step parents or adoptive parents). The mean WISC-R IQ for outpatient children was 101.89 and major reasons for referral were academic and behavioral dysfunction in educational settings (58%) and parent-child family conflict (12%). Eighty-nine percent of these families were white and 11% were black, with roughly 85% from a middle class socioeconomic grouping. All family members were individually administered the MMPI, along with other psychological evaluation instruments, within ten days of initial psychiatric contact. DSM III principal diagnoses for these adolescents resulted in the following groupings: (1) Personality Disorders, 30%; (2) Academic and Cognitive Disorders, 26%; (3) Conduct Disorders, 25%; (4) Adjustment Disorders, 19%. Roughly 95% of these adolescents were placed in outpatient interventions which typically involved combinations of individual and family therapies that entailed less than eight months of treatment duration.

The remaining families were from two inpatient psychiatric settings which serve as psychiatric teaching facilities for the Medical University of South Carolina (66 families) and the Eastern Virginia Medical School (54 families). Both settings are third party reimbursed facilities providing intensive inpatient care for adolescents based upon multidisciplinary team approaches and including individual, family, and group psychotherapies. The median length of stay for the South Carolina facility at the time of data collection in 1978-79 was 137, days and the median length of stay in the Virginia facility during data collection in 1982-84 was 92 days. Preliminary chi-square and t-test analyses revealed no significant age, sex, ethnic or MMPI scale differences between these samples for either parents or adolescents, and these inpatient samples were combined for purposes of data analyses. The combined inpatient sample consisted of 54 female (mean age = 14.51 years) and 66 male adolescents (mean age = 15.01 years), 110 mothers (mean age = 39.37 years) and 94 fathers (mean age = 40.9 years). Six mothers and 19 fathers in this sample were nonbiological parents. The mean WISC or WISC-R IQ for inpatients was 102.3. The families represented a predominantly middle-class socioeconomic background and 90% were white. The MMPI was individually administered to all families within 10 days of the adolescents' ward entry. DSM III diagnoses were unavailable for the South Carolina sample.

Principal DSM III diagnoses, based upon the consensus of treatment team members, were grouped as follows for the Virginia sample: (1) Dysthymic Disorder, 33%; (2) Personality Disorders, 29%; (3) Conduct Disorder, 28%; (4) other diagnoses, 10%.

Procedure:

MMPI results for parents were scored for both raw score values and

T-score values employing adult K-corrected norms. MMPI protocols of adolescents were scored for raw score values and T-score values using age-appropriate adolescent norms as published in Dahlstrom, Welsh, and Dahlstrom (1972). In all cases except chi-square analyses of the frequencies of pathological profiles, data analyses were performed separately for both raw score and T-score values. When such analyses resulted in equivalent patterns of findings, T-score analyses were reported based on the greater meaningfulness of these data for the reader. Twelve children who exhibited impaired reading ability (i.e. below sixth grade) and eight children who were unwilling or unable to accurately respond to the MMPI were excluded from this study. Given the individual MMPI administration procedures allowing for close supervision of respondents, as well as the ambiguity that surrounds the meaning of high F scale elevations (Archer, 1984, Archer et al., 1978), an F scale validity criteria was not employed to exclude subjects in this investigation.

## Results

Initial analyses examined characteristics within the combined samples of inpatient and outpatient families. Mean profile characteristics of parents across samples produced within normal limit profiles with Pd, Hy, and Pa scale high points for mothers and Pd, Hy, and Mf scale high point for fathers. The most frequent clinically elevated scale for both mothers (n = 46) and fathers (n = 33) was Pd, and 41.1% of fathers (n = 81) and 46.7% of mothers (n=92) produced at least one clinical scale elevated within clinical ranges (T score > 70). The most frequently occurring clinical range codetypes for mothers were Hy-Pd (n = 22), D-Pd, (n = 22) and Pd-Pa (n=16), while the most

frequently occurring codetypes for fathers were D-Pd (n=14), Hy-Pd (n=11), and Pd-Mf (n=11). The mean profile characteristics for adolescents across samples revealed a within normal limit profile with Pd, Sc, and Hy high points for girls and Pd, Hy, and D high points for boys.

The results of Pearson correlational analyses of adolescent and parental MMPI raw scores are presented on Table 1, with levels of significance adjusted for multiple correlations using the Bonferroni multistage procedure (Larzelere and Mulaik, 1977). This correction procedure resulted in stage one corrected values for the .05 level of significance which were adjusted to $p<.0038$. Correlational analysis based upon T-score data resulted in equivalent patterns of significant findings with slightly higher correlation values.

Table 1 here

Analyses reveal a substantial number of significant relationships between maternal MMPI raw score values and those of both male and female adolescents. Significant relationships were consistently found for scales Hs, Pd and Sc across analyses of mothers and sons, mothers and daughters, and mothers and the combined adolescent group. In addition, mothers' and fathers' raw scores were significantly interrelated for scales L, Hs, D, Pd, Pt, and Si. Significant relationships between paternal-adolescent scores were restricted to fewer scales than for maternal-adolescent findings.

Chi-square analyses were performed to evaluate relationships in the frequency of pathological profiles between parents and adolescents. Patho-

logical profiles were defined for purposes of these analyses by the presence of any clinical MMPI scale with T-score elevations exceeding 70 for parents and 80 for adolescents. These cutoff scores were selected to produce roughly equal numbers of pathological and nonpathological assignments for parent and adolescent samples. Results of a corrected 2 by 2 chi-square analysis for 197 families comparing frequencies of pathological and nonpathological adolescent profiles by pathological and nonpathological maternal profile were significant, $X^2(1)=4.87$, $p<.05$. Specifically, 60% ($n = 72$) of all adolescent nonpathological profiles occurred among adolescents with nonpathological maternal profiles and 57.1% ($n = 44$) of all adolescent pathological profiles occurred among adolescents with pathological maternal profiles. Chi-square analyses examining paternal profile elevation, either alone or in combination with maternal clinical elevations, indicated nonsignificant relationships to adolescent elevations.

A number of analyses were performed evaluating differences between the inpatient and outpatient samples in this study. Two way analyses of variance (ANOVAs) were performed to examine the effects of sex (male/female) and setting (inpatient/outpatient) on adolescent MMPI T-scores and parental MMPI T-scores (see Table 2 and Figure 1 and 2).

Table 2 Here

Figures 1 and 2 Here

Results of ANOVAs of adolescent T-scores show significantly higher values for

inpatients on MMPI scales L, F, Hs, D, Hy, Pd, Pa, Pt, Sc, Ma, and Si than for their outpatient counterparts. Main effects for sex were noted only on scale Mf, with females producing a lower mean value than males. Three significant setting by sex interactions were found on scales Hs, Pt and Sc. Duncan New Multiple Range subsequent tests on the Hs interaction showed significant differences between all mean values in the following order: male inpatients scored higher than female inpatients who scored higher than female outpatients, with the male outpatients' mean value lower than all other groups. Subsequent comparisons for the Pt and Sc scales revealed that male outpatients were significantly lower than all other groups, with the latter groups equivalent to each other. ANOVA findings for parental T-score analyses revealed that parents of inpatient adolescents scored significantly higher on scales F, Hs, D, Hy, Pd, Pt, Sc, Ma, and Si, and lower on K, than did parents of outpatients. Further, significant main effects were found for sex such that mothers scored significantly lower on scale Mf than mean values for fathers. No significant interactions were found for ANOVAs of parental T-score values.

Chi-square analyses were employed to evaluate the frequency of maternal and paternal profiles producing clinical range (T-score >70) elevations as a function of treatment setting. While the proportion of paternal profiles with clinical range elevations was constant across inpatient (41.1%) and outpatient (39.7%) settings, maternal clinical range elevations occurred with a significantly higher frequency ($X^2(1) = 6.80$, $p<.01$) in inpatient (46.7%) than outpatient (34.6%) settings.

A series of four stepwise discriminant function analyses were performed which employed an F to enter or remove value of 1.0. These analyses were used to evaluate the optimal combination of MMPI scales, based on T-score values, in predicting adolescents' inpatient and outpatient placement. Based exclusively on adolescents' MMPI T-score values, a weighted combination of scales Hs, L, Ma, Pa, Hy, D, and Pt resulted in accurate classification of 68.1% of inpatients and 75.6% of outpatients for an overall accuracy value of 71.07%. Based exclusively on maternal MMPI responses, the optimal combination of scales Pt, Ma, Si, Hs, Mf, and F achieved 62.7%, 70.3%, and 65.62% accuracy, respectively, for the inpatient, outpatient and overall categories. Analyses of paternal MMPI responses indicated that all scales failed to meet the F to enter criteria for participation in the discriminative function. Finally, all the scales for adolescents and mothers which had been identified in the above analyses as significant predictors were combined and these 13 variables employed to predict adolescent placement status with adolescent scales entered before maternal scales. The following eight step weighted equation, involving five adolescent scales and three maternal scales, resulted in 74.6%, 74.3% and 74.5% accuracy, respectively, for inpatient, outpatient and overall classification accuracy:

.84 L (adol.) + .47 Hs (adol.) + .56 D (adol.) + .48 Hy (adol.) + .85 Ma (adol) + .95 Ma (maternal) + .98 Si (maternal) + .95 Mf (maternal)

## Discussion

Overall findings indicate significant interrelationships between adolescent and parent MMPI features among families with adolescent members entering inpatient or outpatient treatment settings. The overall pattern of

adolescent-parent correlations indicates modest but significant relationships (r=.22 to r=.37) between type and intensity of psychological symptomatology reported by adolescents on treatment entrance and parental psychopathology, particularly maternal self reports. Furthermore, results show substantial profile elevation differences for both adolescents and parents as a function of adolescents' treatment placement or setting, with higher MMPI scores found for inpatient family members across most MMPI indices. These findings are the first clear indications in the MMPI literature that degree of parental psychopathology is related to adolescents' degree of disturbance as reflected in treatment setting placement. This observation is underscored by the finding that maternal MMPI features are significantly predictive of the adolescent's placement in inpatient and outpatient settings.

The concepts that important and meaningful relationships exist between parental and adolescent functioning, and that parents of adolescent inpatients report more marked symptomatology than parents of less disturbed outpatient adolescents, are congruent with basic assumptions of numerous family therapy theorists (e.g., Bowen, 1961; Guerin, 1976; Minuchin and Fishman, 1981). Indeed, such notions have served as the basic tenets in efforts to involve family members in the psychiatric treatment of children and adolescents. The additional findings, however, of stronger maternal-adolescent relationship in contrast to paternal-adolescent features has received much less theoretical emphasis.

The evidence for a differential parent-adolescent relationship pattern as a function of sex of parent is provided in a variety of statistical approaches

used in this study. Correlational analyses produced three times as many significant maternal-adolescent MMPI scale associations as paternal-adolescent values. Further, chi-square analyses showed that the presence of maternal clincial range MMPI elevations were related to the frequency of adolescent profiles containing marked clinical elevations, while paternal elevations were unrelated to adolescent profiles. Finally, multivariate discriminant function analyses indicated that the optimal prediction of adolescent placement involved the linear combination of adolescent and maternal, but not paternal, MMPI scale data. Taken together, these findings suggest that maternal-adolescent MMPI features hold differentially stronger relationships to type and degree of psychopathology and placement in inpatient or outpatient treatment than do shared features between psychiatrically disturbed adolescent and their fathers.

Jessor and Jessor (1974) have also reported differential patterns of parent-adolescent interrelationshisps as a function of sex of parent. Specifically, the authors correlated parents' self-reports of attitudes toward traditional beliefs and values, quality of parent-child interactions and orientation to child control and limit setting with adolescents' self-reports of problem behaviors such as drug or alcohol abuse and premarital sexual intercourse. Numerous significant relationships were found between maternal and adolescent responses ($r=.22$ to $r=.42$), but paternal-adolescent correlations were largely nonsignificant. Similarly, Lachar and Sharp (1979) reported twice as many significant correlations between maternal MMPI scale values and ratings of adolescent characteristics on the Personality Inventory

for Children scales relative to paternal-child relationships on these measures. The authors also noted that maternal MMPI scores, but not paternal scores, were related to a variety of clinicians' ratings of parenting behaviors and attitudes such as inconsistent limiting setting as observed in their clinic setting. Lachar and Sharp concluded that "mother-child interactions may have a greater influence on children's behavior than do father-child interactions" (p.236). Finally, Sperling (1970) has emphasized the differential relationship of maternal pathology to child psychopathological development based on three decades of psychoanalytic studies of disturbed children and their families. Sperling stated that maternal neurotic symptomology tends to be more central in both the development and treatment of child disorders than paternal features. She attributed this observation to the passive-dependent features of fathers in her studies which resulted in their withdrawal from parenting responsibilities, and to conflicts concerning anger, maternal role discomfort, and over controlling aspects of maternal personalities resulting in neurotic over-involvement with their children. While highly speculative, the current findings of higher Pa and Sc scores for mothers, reflecting greater hostility and sense of alienation, and higher Mf scores for fathers, reflective of greater passivity, may provide qualified support for Sperling's hypotheses.

While concluding that current findings indicate the relative importance of maternal features to adolescent psychological functioning, substantial caution should be exercised in attributing causal models to these results. Psychoanalytic writers have frequently viewed child pathological development

as a result of maternal pathogenic characteristics and behaviors (e.g. Sperling, 1970; Spitz, 1970). In contrast, however, Erickson (1969) has noted that the elevated MMPI profiles typically found for parents of psychiatrically disturbed children may, at least in part, be reflective of the parental reaction or response to the daily intense stress involved in caring for a deviant child. Evidence for both the psychoanalytic and the stress reaction hypotheses has been limited and mixed. Given the modest relationships found between maternal and adolescent self-reports of symptomatology, it is unlikely that child psychopathology is exclusively or even predominantly accounted for by parental personality features. In contrast, however, it also seems unlikely that the Pd elevation (a scale typically viewed as a trait measure) elevations consistently found among parents of psychiatrically disturbed children in this and other studies (e.g. Lachar and Sharp, 1979; Liverant, 1959; Goodstein and Rowley, 1961; Marks, 1961; Wolking et al. 1966) is exclusively or even predominantly the result of a generalized "stress reaction." The attribution of unidirectional models of causality may ultimately prove less productive than conceptualizations developed by Bell (1979) and others that the parent-offspring interaction is reciprocal and bidirectional in nature and that "the responses of each participant serve not only as the stimuli for the other but also change as a result of the same stimulus exchanges, leading to the possibility of altered response on the part of the other" (p. 822).

Several directions for future investigations appear indicated. The literature on parent-child relationships, including the MMPI studies in this

area, have typically been conducted employing families with at least one psychiatrically disturbed member. Thus, as noted by Hafner et al. (1969), there is little reference data based on studies of normal families with which to evaluate patterns such as those found in the present data. While studies of normal families would be expected to utilize less pathology-oriented instruments than the MMPI, meaningful comparisons with the MMPI literature should be possible. Further, recent research by Smith et al. (1984) indicated that the strength of MMPI relationships between mothers and inpatient adolescents may vary substantially as a function of time of assessment during the adolescent's treatment process. Longitudinal research may not only provide a view of these relationships as they unfold across time, but also aid in understanding the degree to which such relationships reflect long standing trait personality characteristics or more transient and acute state processes and responses (Spielberger, 1966). Finally, as noted by both Hafner et al. (1969) and Lachar and Sharp (1979), while most MMPI studies of family members have typically assumed that evidence of shared characteristics between parent and child is mediated through specific patterns of interactional behaviors, efforts to identify these mediating patterns have seldom been attempted. The current study provides evidence of meaningful relationships between what parents and adolescents report about themselves in terms of pathological symptoms at the time of the adolescent's entrance into treatment. Further, these findings support the importance of treatment efforts, particularly in adolescent inpati[illegible] settings, which are responsive to the psychological features of the p[illegible]nts as well as the symptomatology of the adolescent

patient. While an important first step, these efforts must eventually be grounded in empirical research concerning observable behavioral indices and interactional patterns which serve to bring about findings such as those presently reported.

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## Author Notes

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Correlations for MMPI Raw Scores of Adolescent Patients and their Parents

| MMPI SCALES | Total Sample (n=161) Patient-father | Total Sample (n=192) Patient-mother | Total Sample (n=156) Mother-father | Male Patients (n=98) Son-father | Male Patients (n=115) Son-mother | Female Patients (n=63) Daughter-father | Female Patients (n=77) Daughter-mother |
|---|---|---|---|---|---|---|---|
| L | .01 | .08 | .28* | -.11 | .05 | .17 | .10 |
| F | .03 | .18 | .14 | -.07 | .17 | .24 | .21 |
| K | .00 | .23* | .14 | .05 | .27* | -.08 | .17 |
| Hs(1) | .17 | .32* | .24* | .24 | .31* | .03 | .34* |
| D(2) | .11 | .10 | .22* | .08 | .08 | .15 | .14 |
| Hy(3) | .15 | .27* | .04 | .24 | .20 | .01 | .34* |
| Pd(4) | .27* | .29* | .30* | .20 | .29* | .36* | .29* |
| Mf(5) | .23* | .05 | .12 | .37* | .01 | .07 | .21 |
| Pa(6) | -.02 | .17 | .00 | -.02 | .21 | .00 | .12 |
| Pt(7) | .09 | .25* | .21* | .07 | .20 | .13 | .32* |
| Sc(8) | -.02 | .28* | .14 | .06 | .24* | -.15 | .34* |
| Ma(9) | .15 | .05 | .09 | .17 | .09 | .10 | .01 |
| Si(0) | .10 | .15 | .28* | .11 | .21 | .09 | .09 |





*p < .05 when corrected using a two-tailed multistage Bonferroni procedure with an adjusted stage one value of p < .0038.

Results of Analyses of Variance Evaluating the Effects of Inpatient or Outpatient Setting and Sex and Parents' and Adolescents' MMPI T-Scores

| | ADOLESCENT | | | PARENT | | |
|---|---|---|---|---|---|---|
| Scale | Setting | Sex | Setting By Sex | Setting | Sex | Setting By Sex |
| L | 4.68* | .97 | .35 | .29 | .23 | .29 |
| F | 13.00*** | 3.02 | .74 | 7.10** | .14 | .94 |
| K | 1.25 | 1.25 | 3.22 | 6.27* | 2.19 | 1.35 |
| Hs(1) | 29.14*** | .33 | 4.83* | 33.43*** | .61 | .17 |
| D(2) | 18.45*** | .03 | 1.36 | 5.38* | .12 | .13 |
| Hy(3) | 9.40** | 1.21 | 1.17 | 6.64** | .12 | .10 |
| Pd(4) | 8.03** | .04 | .18 | 21.43*** | 2.44 | .21 |
| Mf(5) | .33 | 10.76*** | 1.53 | 1.77 | 156.10*** | .81 |
| Pa(6) | 18.82*** | .29 | 3.29 | .10 | 4.39* | 2.22 |
| Pt(7) | 12.87*** | .40 | 7.53** | 22.02*** | .21 | 1.83 |
| Sc(8) | 16.33*** | 3.56 | 4.31* | 19.48*** | 2.99 | 1.03 |
| Ma(9) | 8.31** | 1.67 | .03 | 14.72*** | .23 | 1.18 |
| Si(0) | 6.59* | .05 | .35 | 6.73** | 12.75*** | 2.71 |

*p < .05, **p < .01, ***p < .001

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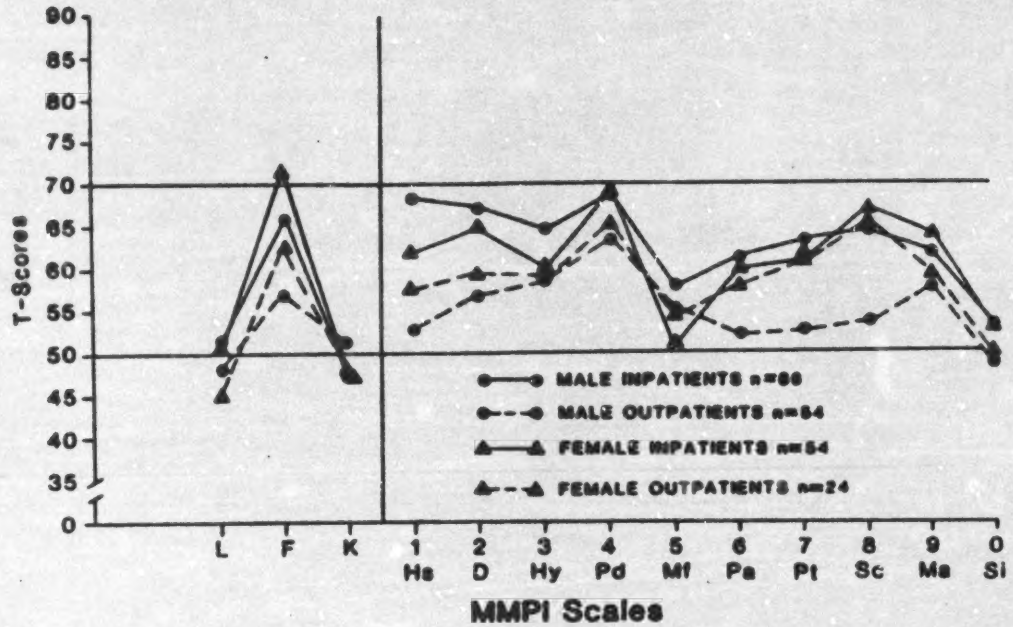
**Mean MMPI T-Scores for Adolescent Male and Female Inpatients and Outpatients**




**Mean MMPI T-Scores for Fathers and Mothers of Inpatient and Outpatient Adolescents**